

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

12/11/15
mw

PRINTED: 12/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2015
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NAME OF PROVIDER OR SUPPLIER DONNELSON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 901 STATE STREET DONNELSON, IA 52625
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<p><i>DW</i> <i>ok</i> <i>12-14-15</i></p> <p>F 000</p>	<p>INITIAL COMMENTS</p> <p>Corrected on 12/11/15.</p> <p>Correction date: _____</p> <p>Findings during the onsite investigation found facility reported incident # 55626-I substantiated with the following deficiency.</p> <p>Investigation of facility-reported incident #55918-I did not result in deficiency.</p> <p>See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.</p>	F 000		
	<p>F 323 SS=K</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interviews, and a tour of the building, the facility failed to provide adequate supervision and monitoring to ensure residents were protected from hazards in the environment with concerns identified for 16 of 27 residents residing in the facility. Resident #1 eloped from the facility without staff's knowledge on 10/7/15. Record review identified Resident #1 resided on the CCDI unit (a special unit or facility dedicated to the care</p>	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	<p>Continued From page 1</p> <p>of persons with chronic confusion or a dementing illness). Observation on 11/3/15 and staff interview revealed the main entrance door of the facility did not have an alarm to alert staff if one of 16 mobile residents without Wander-Gard devices left the building. Interviews revealed the facility did not have a monitoring system to ensure residents safety. The findings constitute an immediate jeopardy to residents health and safety. The facility identified a census of 46 residents.</p> <p>Findings Include: The quarterly Minimum Data Set (MDS) assessment dated 7/14/15 indicated Resident #1 had a moderately impaired cognition with short term and long term memory loss. The MDS delirium assessment revealed the resident had fluctuating problems with inattention and disorganized thinking. During the seven day MDS assessment period the resident was noted to have wandering behaviors daily. The MDS revealed the resident was independent for ambulation and transfers and the resident's balance for walking and turning was steady. The resident's primary diagnosis was non-Alzheimer's dementia.</p> <p>The plan of care for Resident #1, revised 7/22/15, identified the resident as a wanderer and a goal to maintain his/her safety. The care plan interventions included placement in the CCDI unit, the use of a Wander-Gard device (a bracelet, usually applied to the resident's wrist or ankle, which triggers an audible alarm if the resident attempts to open and exit a door equipped with a Wander-Gard alarm), distraction with pleasant diversions, identify the pattern of wandering, monitor the resident's location, and provide structured activities.</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>Review of Progress notes (Nurse's Notes) dated 10/7/15, noted Staff A, Registered Nurse (RN), documented the resident got out of the patio area through the gate at 4:10 p.m. and was found by Staff B, Licensed Practical Nurse (LPN) and brought back into the building.</p> <p>During an interview on 11/3/15 at 11:42 a.m. with Staff A, she stated on 10/7/15 at 3:40 p.m. she noted Resident #1 had been alone on the fenced in patio. At approximately 4:10 p.m. Staff B came to her and stated she had found the resident standing by the facility parking lot when she drove onto the lot. Staff A stated the resident was returned to the CCDI unit and a head to toe assessment was completed. There were no injuries noted. Staff A stated the outside patio is enclosed by a fence and the fence gate is secured by a padlock to prevent residents from leaving the fenced in area. The patio gate exits out to the rear of the building and the employee parking lot and smoking area. She stated on warm sunny days the door to the outside patio is left open so CCDI residents can go in and out of the patio area as they want. She stated the day the resident left the patio the padlock was found to be unlocked with the chain hanging from the fence.</p> <p>During an interview on 11/3/15 at 10:00 a.m. with the Administrator he stated he investigated the elopement thoroughly and interviewed staff present at the time. He stated he was unable to identify which staff member left the padlock unlocked. He stated he suspected an employee took a short cut through the gate to get to the "smoke shack" break area outside of the fenced in patio but he was unable to identify which employee it was. He stated all staff have a key to the padlock as a fire precaution and are instructed not to use the gate unless there is an</p>	F 323			

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F 323	Continued From page 3 emergency requiring the facility to be evacuated. During an interview on 11/3/15 at 11:15 a.m. with Staff C, Maintenance Supervisor, he stated the gate is only used and unlocked for the purpose of moving resident furniture or large items in and out of the building and for yard work. He stated he checks the padlocks quarterly and replaces them is they are rusty or difficult to unlock. He stated several weeks ago he was doing yard work in the patio area and unlocked the gate to leave the area to retrieve a weed-eater that was located at the nearby corner of the yard. He stated Resident #1 left the patio through the gate he unlocked and was immediately brought back through the gate by the Director of Nurses who witnessed the resident leaving. He stated this incident was reported to the Department of inspections and Appeals and was deemed to be "no investigation ". He stated he always locks the gate after himself now even if just leaving for a few seconds to retrieve work equipment. During an interview with Staff D at 1:25 p.m. on 11/3/15, she stated the resident likes to go out to the patio and walk along the fence. Staff D reported the resident would pull on the fence and gate [when outside]. During an interview with Staff E, CNA on 11/3/15 at 1:15 p.m. she stated sometimes the resident pushes hard enough to " pop " doors open and alarms go off, thus staff are aware he/she was trying to get out. During an interview with the Director of Nursing (DON) on 11/3/15 at 2:00 p.m. she provided documentation flow-sheets of the alarm checks the nursing staff completes each shift. She stated prior to the elopement of Resident #1 staff would check the Wander-Gard devices, the Door #1 Wander-Gard alarm, and the other exit door alarms at the beginning of each shift. Review of	F 323			

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F 323	Continued From page 4 the flow-sheets revealed staff were consistently completing and documenting the checks. After the elopement incident with Resident #1 the Director of Nursing added padlock gate checks to the flow sheets to be done each shift when door alarms were checked. In addition, signs reminding staff to keep the gates locked were posted at each gate. She stated her staff is very familiar with the residents in the main part of the building and aware of their routines. She felt her staff offered appropriate and adequate supervision to these residents in the main part of the facility but acknowledged if a resident without a Wander-Gard device became confused and accidentally wandered out the front door staff would not be alerted. The DON stated all residents have elopement risk assessments completed on admission and quarterly at the care plan meetings. She stated any resident with a risk score of 10 or higher has a Wander-Gard device placed on their body. Any resident who exhibits exit seeking behaviors also is assessed for the placement of a Wander-Gard device. Family members are consulted about the need for a device in the event that a resident requires one. During a tour of the building on 11/3/15 at 10:30 a.m. with the Administrator and Staff C, Maintenance Supervisor, it was noted there were a total of seven exit doors to the outside of the building (Doors #1, #2, #4, #6,#7,#8, and #9). Six exit doors (Door #2, #4, #6, #7, #8 and #9) had alarms and would sound any time the door was opened. Door #1 (main entrance) was alarmed with a Wander-Gard alarm and would only alarm if a resident with a Wander-Gard device attached to their body attempted to exit the door. During the tour, doors #7, #8, and #9 led to a large fenced in courtyard with two exit gates	F 323			

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F 323	<p>Continued From page 5</p> <p>secured with padlocks. Door #4 led to the employee parking lot and a code had to be entered on a touch pad to unlock the exit. Door #6 was the door to the CCDI outside patio with the gate from which the resident eloped. This door had an alarm which would sound when opened but was left open by staff on warm sunny days. Door #2 led to the side driveway from the parking lot. Door #1 was the front entrance door with the Wander-Gard alarm and opened onto the front visitor parking lot. Interview with the Administrator at the time of the tour revealed Door #1 was not locked at night. He agreed it was possible for residents to leave the facility by the front entrance door without staff being made aware of their exit.</p> <p>Review of facility census revealed there were 27 residents in the main part of the facility (excluding the 19 residents in the CCDI unit). The DON stated of these 27 residents 5 of them had Wander-Gard devices due to intermittent confusion. Of the remaining 22 residents without Wander-Gard devices 16 of the residents were mobile (ambulatory or self-propelling with a wheelchair) and could possibly leave the building without alerting staff; of these 16 residents, 7 residents had cognitive impairments according to their MDS assessments. These 7 residents scored 11 and below on their Brief Interview for Mental Status (BIMS) which revealed cognitive impairment ranged from severe to moderate cognitive impairments.</p> <p>During an interview on 11/5/15 at 10:00 a.m. with the Administrator he stated the main entrance door (#1) has an alarm on it in addition to the Wander-Gard alarm. He stated there was no by-pass button so the door alarmed every time someone entered or exited the building. For this</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>reason the alarm was not activated and not used routinely. He stated the alarm now is activated (became activated on 11/3/15) and a service company is adding a by-pass button on the outside of the door and a code pad lock on the inside. This allows staff and visitors to by-pass the alarm when entering or exiting the building. This alarm will alert staff if any resident attempts to leave the building day or night.</p> <p>After the resident eloped from the facility the facility completed the following corrective actions:</p> <ol style="list-style-type: none"> 1. When residents are outside on patio or courtyard, staff will have eye on supervision. 2. The staff will check the gates three times a day. 3. On 11/3/15 added signs reminding staff to keep the gates locked were posted at each gate. 4. The facility posted education for all staff to review. 5. The facility completed 1:1 education with all staff. 6. The DON added padlock gate checks to the flow sheets for staff to complete each shift when the door alarms were checked. <p>The facility posted the following sign: The alarm switch to activate the alarm for the front door must be turned on whenever the receptions [staff] are not in the front office. We must do it this way until arrangements can be made for a bypass switch to be installed. This is a safeguard again a resident leaving the building without staff knowledge.</p> <p>The facility abated the IJ on 11/3/15 when they activated the alarm on the front entrance door. The facility will review with a service company to consider adding a by-pass button on the outside of the door and a code pad lock on the inside.</p>	F 323			

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F 323	Continued From page 7 These actions lowered the IJ from a K severity to a E severity with the need for ongoing monitoring to ensure residents received adequate supervision.	F 323		

Donnellson Health Center

Plan of Correction Incident # 55626-I

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law.

F323

Following the elopement of Resident #1 the facility made significant changes to the system of checks in our CCDI unit. We added daily padlock checks to all gates, staff education and signs were posted to all Patio Gates as a reminder to all staff that the gates must remain locked at all times.

With regard to the residents residing on our Front Hall (off the CCDI Unit); at the time the issue was identified (11/3/2015) we activated an alarm on the door that connects to our Fire System. This meant that anytime the door was opened an alarm would sound at the Nurse's Station. We then contacted a local electrician who installed a permanent ByPass button on the *exterior* of the facility under the Handicap Automatic Door openers.

The electrician then installed a small ByPass button on the *inside* of the facility in the vestibule. This button is located on the side of the external door opening mechanism (above the reach of residents). This button was installed on 11/10/2015. The door alarm is to be activated at all times, unless the Assistant Administrator is monitoring the front door from her desk.

We further intend to have a Coded Keypad installed at regular height to allow ByPass of the alarm system. This Keypad will have the ability to change the code as needed.

The Director of Nursing will monitor the alarm system to ensure activation. Staff and resident education will be provided as needed on an ongoing basis as to the need for the alarm system.

Implementation timeframe:

Abated by activation of the Alarms: 11/3/2015

Completion of ByPass Switch Installation: 11/10/2015